

		FOR OHF USE					

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**2000**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2000)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0038208</u>  <b>Facility Name:</b> <u>ANDOVER</u>  <b>Address:</b> <u>4636 W. Andover</u> <u>PEORIA</u> <u>61615</u> <div style="text-align: center;">Number City Zip Code</div> <b>County:</b> <u>PEORIA</u>  <b>Telephone Number:</b> <u>309 691-1736</u> <b>Fax #</b> <u>309 689-3613</u>  <b>IDPA ID Number:</b> <u>###</u>  <b>Date of Initial License for Current Owners:</b> <u>6/4/93</u>  <b>Type of Ownership:</b> <table border="0" style="width: 100%;"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> <u>501(C)3</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>STUART SCHMITT</u> <b>Telephone Number:</b> <u>(309) 691-3800</u>		<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> <u>501(C)3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>  <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/99</u> to <u>06/30/00</u> and certify to the best of my knowledge and belief that the said content: are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment</p> <table border="1" style="width: 100%;"> <tr> <td rowspan="2"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="2"></td> <td>(Type or Print Name) <u>STUART SCHMITT</u></td> </tr> <tr> <td>(Title) <u>VICE PRESIDENT</u></td> </tr> <tr> <td rowspan="4"><b>Paid Preparer</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name &amp; Address) _____</td> </tr> <tr> <td colspan="2">(Telephone) <u>( )</u> Fax # <u>( )</u></td> </tr> <tr> <td colspan="2"> <b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> <div style="text-align: right;"><b>Phone # (217) 782-1630</b></div> </td> </tr> </table>		<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____		(Type or Print Name) <u>STUART SCHMITT</u>	(Title) <u>VICE PRESIDENT</u>	<b>Paid Preparer</b>	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>( )</u> Fax # <u>( )</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> <div style="text-align: right;"><b>Phone # (217) 782-1630</b></div>	
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DPA 3745 (N-4-99)

IL478-2471

**Print Preview**

Facility Name & ID Number ANDOVER# 0038208 Report Period Beginning: 07/01/99 Ending: 06/30/00

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>16</u>	Intermediate/DD	<u>16</u>	<u>5,856</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,856</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>5,685</u>			<u>5,685</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>5,685</u>			<u>5,685</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.08%D. How many bed-hold days during this year were paid by Public Aid?  
93 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)  
NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES ☐ NO ☒I. On what date did you start providing long term care at this location?  
Date started        /        /        SEE DATES OF INITIAL LICENSEJ. Was the facility purchased or leased after January 1, 1978?  
YES ☐ Date        NO ☒K. Was the facility certified for Medicare during the reporting year?  
YES ☐ NO ☒ If YES, enter number of beds certified        and days of care provided       Medicare Intermediary       

## IV. ACCOUNTING BASIS

MODIFIED  
ACCRUAL ☒ CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 6/30/00 Fiscal Year: 6/30/00

\* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 07/01/99 Ending: 06/30/00  
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
Operating Expenses	Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services										
1 Dietary		1,942	1,643	3,585	34,065	37,650	0	37,650		1
2 Food Purchase		37,083		37,083		37,083	364	37,447		2
3 Housekeeping	4,601	3,976		8,577	4,940	13,517	151	13,668		3
4 Laundry		1,062		1,062		1,062	0	1,062		4
5 Heat and Other Utilities			17,028	17,028		17,028	946	17,974		5
6 Maintenance	9,182	7,083	6,152	22,417		22,417	2,755	25,172		6
7 Other (specify):*		218	3,358	3,576		3,576	195	3,771		7
8 TOTAL General Services	13,783	51,364	28,181	93,328	39,005	132,333	4,411	136,744		8
B. Health Care and Programs										
9 Medical Director			902	902		902	6	908		9
10 Nursing and Medical Records	425,264	2,921	524	428,709	(39,005)	389,704	65	389,769		10
10a Therapy	9,652	403	2,378	12,433		12,433	0	12,433		10a
11 Activities		159	1,200	1,359		1,359	0	1,359		11
12 Social Services	745			745		745	0	745		12
13 Nurse Aide Training	3,630	125		3,755		3,755	0	3,755		13
14 Program Transportation			7,753	7,753	(492)	7,261	0	7,261		14
15 Other (specify):*			1,868	1,868		1,868	0	1,868		15
16 TOTAL Health Care and Programs	439,291	3,608	14,625	457,524	(39,497)	418,027	71	418,098		16
C. General Administration										
17 Administrative	14,620			14,620		14,620	20,916	35,536		17
18 Directors Fees							0			18
19 Professional Services			159	159		159	4,683	4,842		19
20 Dues, Fees, Subscriptions & Promotions			4,239	4,239		4,239	1,561	5,800		20
21 Clerical & General Office Expenses	8,463	1,112	4,576	14,151	1,815	15,966	31,715	47,681		21
22 Employee Benefits & Payroll Taxes			105,866	105,866		105,866	10,908	116,774		22
23 Inservice Training & Education			33	33		33	214	247		23
24 Travel and Seminar			664	664		664	543	1,207		24
25 Other Admin. Staff Transportation							158	158		25
26 Insurance-Prop.Liab.Malpractice			4,375	4,375		4,375	716	5,091		26
27 Other (specify):*			128	128		128	522	650		27
28 TOTAL General Administration	23,083	1,112	120,040	144,235	1,815	146,050	71,936	217,986		28
29 TOTAL Operating Expense (sum of lines 8, 16 & 28)	476,157	56,084	162,846	695,087	1,323	696,410	76,418	772,828		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number ANDOVER # 0038208 Report Period Beginning: 07/01/99 Ending: 06/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	<b>D. Ownership</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>			
30	Depreciation			23,517	23,517		23,517	5,350	28,867			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			3,179	3,179		3,179	3,839	7,018			32
33	Real Estate Taxes							0				33
34	Rent-Facility & Grounds							0				34
35	Rent-Equipment & Vehicles			1,815	1,815	(1,815)		0				35
36	Other (specify):*							0				36
37	<b>TOTAL Ownership</b>			28,511	28,511	(1,815)	26,696	9,189	35,885			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation					492	492	0	492			38
39	Ancillary Service Centers							0				39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			51,224	51,224		51,224	0	51,224			42
43	Other (specify):*							0				43
44	<b>TOTAL Special Cost Centers</b>			51,224	51,224	492	51,716		51,716			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	476,157	56,084	242,581	774,822	0	774,822	85,607	860,429			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>CONFERENCE EXPENSE</u>		(78)		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$	(78)	\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	85,685		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 85,685		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ 85,607		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.	X		\$ 492	V14	38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$ 492		47



**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.  
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ANDOVER

# 0038208 Report Period Beginning:

07/01/99

Ending: 06/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	0	0	0	0	0	0	0	0	0	0	0	0	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	0	0	0	0	0	0	0	0	0	0	0	0	29

**DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.**

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.  
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ANDOVER

# 0038208

Report Period Beginning:

07/01/99

Ending:

06/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	0	0	0	0	0	0	0	0	0	0	0	0	37
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	0	0	0	0	0	0	0	0	0	0	0	0	44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	0	0	0	0	0	0	0	0	0	0	0	0	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.





Facility Name &amp; ID Number ANDOVER

# 0038208

Report Period Beginning: 07/01/99

Ending: 06/30/00

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NONE								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

[Print Preview](#)

Facility Name & ID Number **ANDOVER**# **0038208**Report Period Beginning: **07/01/99**Ending: **06/30/00**

## VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D

Show Pgs 8E thru 8I

Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

PEORIA ASSN. FOR RETARDED CIT.

Street Address

1913 TOWNLINE RD., P. O. BOX3418

City / State / Zip Code

PEORIA, IL 61612

Phone Number

( 309) 691-3800

Fax Number

( 309) 689-3613

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	FOOD	% OF DIRECT COST	12,169,667	12	\$ 5,899	\$	751,305	\$ 364	1
2	3	HOUSEKEEPING	"	12,169,667	12	2,451		751,305	151	2
3	5	HEAT & OTHER UTILITIES	"	12,169,667	12	15,321		751,305	946	3
4	6	MAINTENANCE	"	12,169,667	12	44,619		751,305	2,755	4
5	7	OTHER GENERAL SERVICES	"	12,169,667	12	3,158		751,305	195	5
6	9	PHYSICIAN FEES	"	12,169,667	12	105		751,305	6	6
7	10	NURSING & MED. RECORDS	"	12,169,667	12	1,059		751,305	65	7
8	17	ADMIN. SALARIES	"	12,169,667	12	338,793		751,305	20,916	8
9	19	PROFESSIONAL FEES	"	12,169,667	12	77,772	338,793	751,305	4,801	9
10	20	FEES & SUBSCRIPTIONS	"	12,169,667	12	25,497		751,305	1,574	10
11	21	CLERICAL & GENERAL	"	12,169,667	12	484,244		751,305	29,895	11
12	22	EMPLOYEE BENEFITS & TAX	"	12,169,667	12	176,685	425,761	751,305	10,908	12
13	24	TRAVEL & SEMINAR	"	12,169,667	12	17,245		751,305	1,065	13
14	25	OTHER STAFF TRANSP.	"	12,169,667	12	4,192		751,305	259	14
15	26	INSURANCE	"	12,169,667	12	11,595		751,305	716	15
16	27	MISCELLANEOUS	"	12,169,667	12	8,691		751,305	537	16
17	32	INTEREST	"	12,169,667	12	62,188		751,305	3,839	17
18	21	EQUIPMENT RENTAL	"	12,169,667	12	29,484		751,305	1,820	18
19	30	DEPRECIATION	"	12,169,667	12	86,663		751,305	5,350	19
20	23	INSERVICE TRAINING & ED.	"	12,169,667	12	3,461		751,305	214	20
21	19	UNALLOWABLE	"	12,169,667	12	(1,908)		751,305	(118)	21
22	20	UNALLOWABLE	"	12,169,667	12	(212)		751,305	(13)	22
23	27	UNALLOWABLE	"	12,169,667	12	(240)		751,305	(15)	23
24	24	UNALLOWABLE	"	12,169,667	12	(8,828)		751,305	(545)	24
25	TOTALS					\$ 1,387,934	\$ 764,554		\$ 85,685	25

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**Cell:** U40

**Comment:** Formula failed to convert

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	ILLINOIS DEVELOPMENT		X	BOND FINANCING OF	VARIES	7/2/97	\$ 8,025,000	\$ 7,685,000	07/01/19	4.5%	\$ 453,960	1	
2	FINANCE AUTHORITY			FACILITY WHICH INCLUDES						TO		2	
3				CORPORATE OFFICES						6.05%		3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 8,025,000	\$ 7,685,000			\$ 453,960	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 8,025,000	\$ 7,685,000			\$ 453,960	15	

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

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Facility Name & ID Number **ANDOVER**# **0038208**

Report Period Beginning:

**07/01/99**

Ending:

**06/30/00****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes****NONE - TAX EXEMPT**

1. Real Estate Tax accrual used on 1999 report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	2
3. Under or (over) accrual (line 2 minus line 1).	\$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

<b>FOR OFF USE ONLY</b>	
13	FROM R. E. TAX STATEMENT FOR 1999 \$ 13
14	PLUS APPEAL COST FROM LINE 5 \$ 14
15	LESS REFUND FROM LINE 6 \$ 15
16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

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**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 10,000 B. General Construction Type: Exterior VINYL Frame WOOD Number of Stories 1

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground! (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1		57,880	1992	\$ 63,900	1
2					2
3	TOTALS	57,880		\$ 63,900	3

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE  
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B

Show Pgs 12C and 12D

Hide Pgs 12A thru 12D

STATE OF ILLINOIS

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Facility Name & ID Number ANDOVER

# 0038208

Report Period Beginning:

07/01/99

Ending:

06/30/00

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16			1992	\$ 537,233	\$ 13,431	40	\$ 13,431	\$	\$ 153,112	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	ARCHITECT FEES			1994	1,769	44	40	44		433	9
10	LANDSCAPING			1995	2,000	200	10	200		1,000	10
11	LANDSCAPING & PATIOS			1998	7,885	789	10	789		1,972	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$ 14,464		\$ 14,464	\$	\$ 156,517	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number ANDOVER# 0038208

Report Period Beginning:

07/01/99

Ending:

06/30/00

## XI. OWNERSHIP COSTS (continued)

## C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 9,050	\$ 732	\$ 732	\$	5-10	\$ 5,321	37
38	Current Year Purchases	3,898	275	275		5-10	275	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 12,948	\$ 1,007	\$ 1,007	\$		\$ 5,596	41

## D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	CARE RELATED	1997 PLYMOUTH VOYAGER	1997	19,832	4,958	4,958		4	17,353	42
43	BUSINESS/									43
44	COMMUNITY ACCESS									44
45										45
46	TOTALS			\$ 19,832	\$ 4,958	4,958			\$ 17,353	46

## E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 20,429	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 20,429	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 179,466	51

## F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	NONE	\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

## G. Construction-in-Progress

	Description	Cost	
58	NONE	\$	58
59			59
60			60
61		\$	61

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

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**XII. RENTAL COSTS****A. Building and Fixed Equipment (See instructions.)****NONE****1. Name of Party Holding Lease:****2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?**

If NO, see instructions.

☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

**8. List separately any amortization of lease expense included on page 4, line 34.**This amount was calculated by dividing the total amount to be amortized  
by the length of the lease**9. Option to Buy:**☐

YES

☐

NO

Terms:

\*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)****15. Is Movable equipment rental included in building rental?**☐ YES☐ NO**16. Rental Amount for movable equipment:**

\$

Description:

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

**10. Effective dates of current rental agreement:**

Beginning

Ending

**11. Rent to be paid in future years under the current rental agreement:**

Fiscal Year Ending

Annual Rent

12. /2001

\$

13. /2002

\$

14. /2003

\$

\* If there is an option to buy the building,  
please provide complete details on attached  
schedule.\*\* This amount plus any amortization of lease  
expense must agree with page 4, line 34.

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Facility Name & ID Number ANDOVER# 0038208 Report Period Beginning: 07/01/99 Ending: 06/30/00

## XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

## A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.		IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE <u>40</u>
		HOURS PER AIDE <u>80</u>	

## B. EXPENSES

## ALLOCATION OF COSTS (d)

	1	2	3	4
	Facility			
	Drop-outs	Completed	Contract	Total
1 Community College Tuition	\$	\$	\$	\$
2 Books and Supplies		125		125
3 Classroom Wages (a)		2,420		2,420
4 Clinical Wages (b)		1,210		1,210
5 In-House Trainer Wages (c)				
6 Transportation				
7 Contractual Payments				
8 Nurse Aide Competency Tests				
9 TOTALS	\$	\$ 3,755	\$	\$ 3,755
10 SUM OF line 9, col. 1 and 2 (e)	\$ 3,755			

## C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ 

## D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	5

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)   NONE  

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescripts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name &amp; ID Number ANDOVER

## STATE OF ILLINOIS

# 0038208

Report Period Beginning: 07/01/99

Ending:

Page 17

06/30/00

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/00

(last day of reporting year)

This report must be completed even if financial statements are attached.

	PARC, INC.	1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$ 143,965	1
2	Cash-Patient Deposits		85,736	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )		1,436,549	3
4	Supply Inventory (priced at <u>COST</u> )		8,322	4
5	Short-Term Investments		825,049	5
6	Prepaid Insurance		31,958	6
7	Other Prepaid Expenses		42,925	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		233,520	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$	\$ 2,808,024	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land AND LAND IMPROVEMENTS		729,658	13
14	Buildings, at Historical Cost		8,496,974	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		1,622,077	16
17	Accumulated Depreciation (book methods)		(2,974,914)	17
18	Deferred Charges		258,849	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		1,886,930	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$	\$ 10,019,574	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$	\$ 12,827,598	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$	\$ 871,034	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		85,736	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		582,627	30
31	Accrued Taxes Payable (excluding real estate taxes)		604	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		226,962	33
34	Deferred Compensation		599,590	34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$	\$ 2,366,553	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		7,685,000	41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$ 7,685,000	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$	\$ 10,051,553	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$	\$ 2,776,045	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$	\$ 12,827,598	48

\*(See instructions.)

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		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,149,588	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,149,588	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(373,543)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (373,543)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,776,045	24 *

\* This must agree with page 17, line 47.

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Facility Name &amp; ID Number ANDOVER

# 0038208

Report Period Beginning: 07/01/99

Ending: 06/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 869,900	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 869,900	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	5,895	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 5,895	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>ALLOCATION FROM SUPPORT SERVICES</b>	380	28
28a	<b>ALLOCATION FROM CENTRAL OFFICE</b>	9,361	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 9,741	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 885,536	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	\$ 136,744	31
32	Health Care	418,098	32
33	General Administration	217,986	33
	<b>B. Capital Expense</b>		
34	Ownership	35,885	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	492	35
36	Provider Participation Fee	51,224	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 860,429	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	25,107	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 25,107	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation. NO SEPARATE RETURN FOR THE FACILITY

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing	220	232	4,184	18.03	2
3	Registered Nurses	280	328	4,489	13.69	3
4	Licensed Practical Nurses	487	557	7,019	12.60	4
5	Nurse Aides & Orderlies	132	158	1,247	7.89	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	102	118	1,789	15.16	7
8	Rehab/Therapy Aides	883	1,058	11,824	11.18	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	42	50	745	14.90	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,176	1,424	13,783	9.68	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	688	796	11,843	14.88	20
21	Assistant Administrator					21
22	Other Administrative	94	123	2,777	22.58	22
23	Office Manager					23
24	Clerical	932	1,075	8,463	7.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,872	2,080	26,296	12.64	28
29	Resident Services Coordinator	3,326	3,935	38,235	9.72	29
30	Habilitation Aides (DD Homes)	37,795	40,430	343,463	8.50	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	48,029	52,364	\$ 476,157 *	\$ 9.09	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	N/A	\$ 1,623	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	N/A	342	10a-3	40
41	Occupational Therapy Consultant	N/A	1,776	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	N/A	260	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 4,001		49

## C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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## XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	6 Amount of Expense Amortized Per Year								
					5 FY1997	6 FY1998	7 FY1999	8 FY2000	9 FY2001	10 FY2002	11 FY2003	12 FY2004	13 FY2005
1	NONE		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
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8													
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11													
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14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? \_\_\_\_\_
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ unknown Line \_\_\_\_\_
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation. \_\_\_\_\_
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. \_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 51,224  
This amount is to be recorded on line 42 of Schedule V. \_\_\_\_\_
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation. \_\_\_\_\_
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? \_\_\_\_\_ Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? YES If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 492  
c. What percent of all travel expense relates to transportation of nurses and patients? unknown  
d. Have vehicle usage logs been maintained? YES  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
**g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0**
- (17) Has an audit been performed by an independent certified public accounting firm? \_\_\_\_\_  
Firm Name: CLIFTON GUNDERSON, L.L.C. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

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